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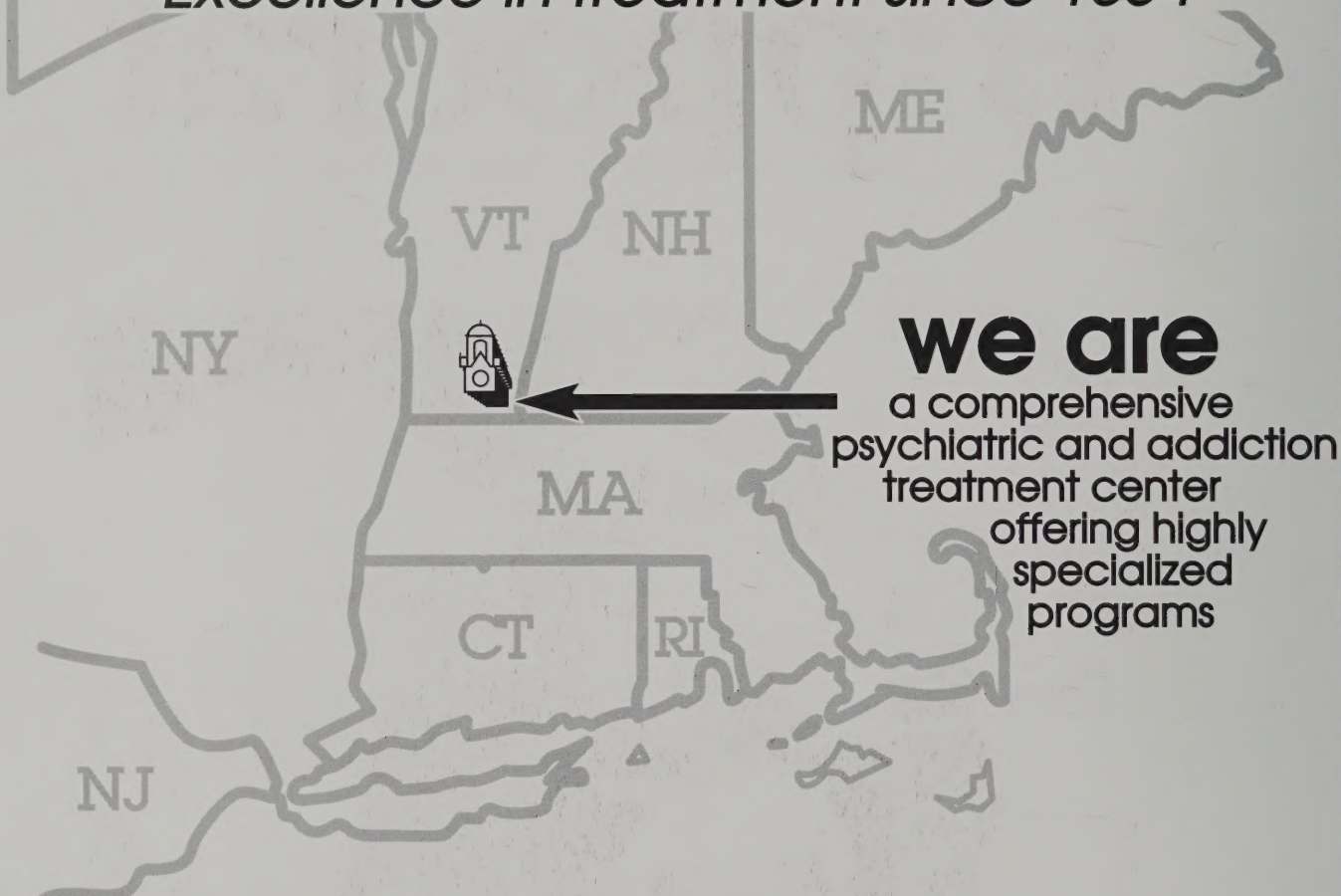
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THE
**Hampden
Hippocrat**
SEPTEMBER—OCTOBER 1991

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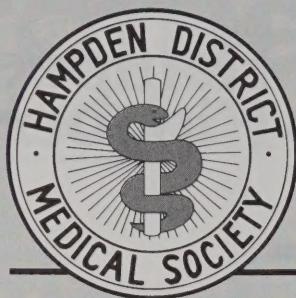
The official bulletin for The Hampden District of the Massachusetts Medical Society. Founded in 1942 by Edward P. Bagg, Jr., M.D. and William A. R. Chapin, M.D.

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Route 5 at Smith's Ferry
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DATE: Tuesday, October 1, 1991

BUSINESS MEETING: 6:00 p.m.

SOCIAL HOUR: 7:00 p.m.

DINNER: 7:30 p.m., Spouses are welcome!

SPEAKER: THE HONORABLE RICHARD E. NEAL
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Washington D.C.

SUBJECT: National Legislative Update

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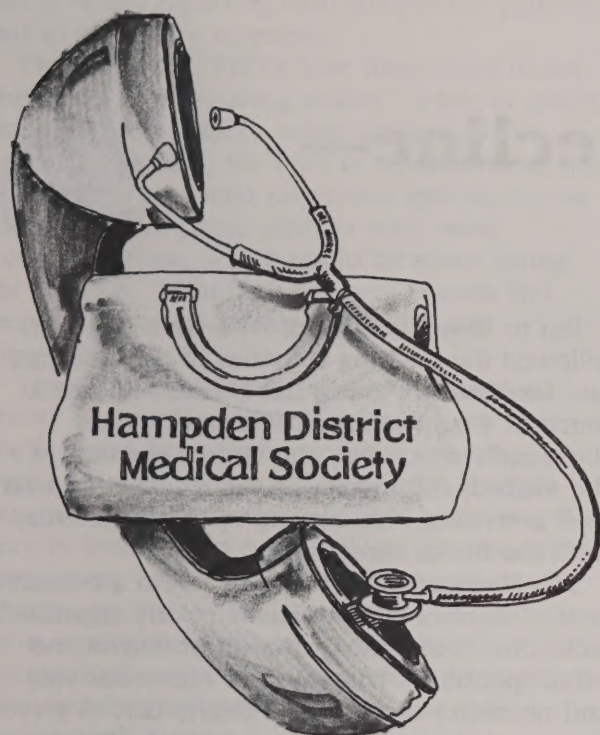
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From the Editors

This issue focuses on anesthesiology. We have an interview with Dr. Howard Tractenberg, and articles from Drs. Alan Harvey and Robert Steinberg about aspects of anesthesiology which those of us who aren't in the field probably don't think about very much.

The cover photo shows some of the faces of anesthesiology at work in the Pioneer Valley. Beginning at the far right and moving clockwise are Dr. Hilary Wonder, a resident at Baystate Medical Center; Dr. Michelle Bilodeau, also at Baystate; Dr. Adam Gailucci, at Mercy Hospital; Dr. Jose Castillo, at Holyoke Hospital; and Dr. Steve Dunn, at Baystate. These photos were taken by co-editor Dr. Brigid Galckin. ■

*Brigid Galckin, M.D.
Donald J. Higby, M.D.
Co-editors*

Shigellosis at Baystate Medical Center:

Approximately one hundred cases of Shigellosis (group D, *S. sonnei*) have been identified in Springfield within the past six weeks. Source of the outbreak has not as yet been identified. Presentation typically is diarrhea, often associated with the urge to defecate and the presence of blood and/or pus in the stool. This is an extremely contagious disease, capable of being spread by the fecal/oral route, often on the hands of patients and hospital personnel. Patients identified or suspected of having Shigellosis should be treated with appropriate antibiotics—the strain identified is resistant to both ampicillin and piperacillin. Alternative agents include TMP/SMX and a quinolone (Bactrim & Cipro).

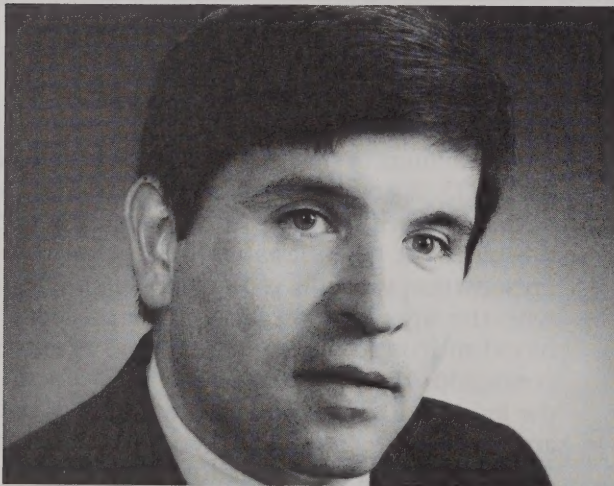
Although adherence to body substance precautions satisfies infection control needs, careful attention to hand washing between patient contacts is imperative to prevent spread of infection among hospitalized patients. Hospital personnel with symptoms of diarrhea, especially if accompanied by the severe urge to defecate or if stools contain blood or pus should report to the Employee Health Service for evaluation. If this service is closed, please report to the Emergency Department. ■

*Richard Brown, M.D.
Director, Infectious Diseases*

The Continuing Decline— Not a Surprise!



The federal government decided to get into the health care business in the 1960s, accompanied by a great deal of fanfare and a promise of coverage for the elderly (Medicare) and the poor (Medicaid). Organized medicine opposed the institution of these plans and was viewed as quite selfish and self-centered.



Mark J. Mullan, M.D., President

Despite physician objections these programs flourished and lo and behold, over the early decades of these "socialized" plans, physicians were likely the greatest beneficiaries. Incomes rose, in some cases exponentially, as more and more patients became good paying customers.

However the goose that laid the golden egg has been dying a slow painful death in the eyes of most practitioners. And now that HCFA has decided arbitrarily to reduce the benefits promised primary care disciplines under the resource-based relative value scale, the last rites are finally being administered.

But to those like myself who have carefully followed the ongoing activities of the Medicare and Medicaid programs this shouldn't come as much of a surprise. On the contrary, I am thoroughly amazed by the violent reaction of the medical community to the recent proposals as if everything was coming up roses yesterday until the floods came today.

The Medicaid program has been in a constant state of disarray. It is inefficient, poorly organized, lacks physician participation in obstetrics and other specialties, fails to cover numerous vital and necessary services and clearly fails to serve the population who requires its' help. While these problems may be obvious to us, they certainly aren't clear to the bureaucrats. Gail Whitensky, the seemingly incompetent HCFA head, recently testified that "Medicaid has met its basic objective and has been effective in serving this population." She must be living on another planet. How can such a complex program ever work if those administering it cannot recognize the major problems and take appropriate measures to correct them?

Medicare is another story. Both physicians and patients have come to depend on it to a degree never imagined. As the number of elderly has risen dramatically, the cost of technology has skyrocketed, and the general demand for services has increased, the cost of the program has become unmanageable. Some were slow coming to this realization, including many M.D.s; but, in retrospect, the cost-cutting axe has been falling painfully for some time.

The changes have been gradual but sure. DRGs were instituted in an attempt to decrease hospital costs, often to the chagrin of doctors and the detriment of patients. Numerous billing and coding changes have complicated office work enormously and participation/non-participation decisions were often agonizing. In

this state, licensure to practice was tied to a legislated ban on balance billing. Decisions on fee changes have continuously been made on an irrational basis and have been more closely tied not to factors impacting costs and practice patterns, but to budgetary restraints.

There is more. PRO's have functioned under the guise of "improving quality" while in reality they are only a thinly veiled attempt to cut costs. If anything, the PRO in Massachusetts has served only to harass physicians into becoming more effective paper pushers who waste countless hours, which could be spent caring for patients, "cleaning" up their records and responding to ridiculous quality of care allegations.

The Clinical Laboratory Act restricting our ability to do office tests and procedures was the system's first attempt to limit our office practices. And now many of us who thought hospital review was sickening are beginning to receive letters from our Medicare intermediary demanding copies of outpatient records and charges on many of our patients. Even the more optimistic physician cannot help but see the detailed audits, fines, hassles and retroactively returned fees and other horrors that these reviews will cause.

After all this verbal diarrhea one might intelligently wonder where all this leads. Well, the fact of the matter is that in the future, in any program involving the state or federal governments, patients and providers are going to be squeezed dry by factors totally unrelated to the provision of health care. Sure, there could be temporary improvements in the conversion factor, Medicaid fees or even the PRO. But whether it be under the present system or in a national health insurance program, our ability to practice quality medicine in an environment both fair to physicians and beneficial to patients will diminish.

There are many docs who at present feel immune from these pressures, including those who may be full-time at hospitals or even at HMOs. But inevitably the involvement of government will increase and the pressures and stresses of the current system will trickle down to those not as affected at present. And at that time we'll all be sinking together.

For a thirty-seven year old who is still somewhat wet behind the ears this is all pretty damn depressing. ■

Approved by The Hampden District Medical Society



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Anesthesiology Outside the Operating Room

Dr. Steinberg, Ph.D., M.D. is a staff anesthesiologist at Baystate Medical Center. His contribution shows the diversity and continuing evolution of his specialty.

When informed of my profession, people often respond, "An anesthesiologist—you put people to sleep, right?" Invariably, my reply is: "Any monkey can do that; anesthesiologists wake you back up." Although this correction improves on the first image, it still does little justice to a complex medical specialty. However, if pressed for a more complete explanation of what I do, I find that I lack a concise description of the practice of anesthesiology. Faithful translation of Greek derivatives would define anesthesiology as the study of anesthesia, the absence of sensation. This simplistic concept belittles the complexities of modern intraoperative patient management, and entirely ignores critical aspects such as pre-operative evaluation of surgical patients and their recovery during the immediate postoperative period. Discussion of such concepts would provide a more thoughtful description of the largest sphere of activity pursued by anesthesiologists: perioperative patient care. So far, so good. But, as the title suggests, other activities must be included to completely flesh out the discipline of anesthesiology. These occur outside our usual sphere of activity in the surgical suite.

Five sirens lure anesthesiologists away from the operating room: research, obstetric anesthesia, critical care, anesthesia in alien environments, and pain management. Each of these can be sufficiently alluring as to dominate one's professional attention.

Five sirens lure anesthesiologists away from the operating room: research, obstetric anesthesia, critical care, anesthesia in alien environments, and pain management.

Indeed, some anesthesiologists have abandoned their original mistress (or gigolo, as must be added in the interest of preserving gender-neutral terminology) of surgical patient care, to better to indulge their infatuation with a subspecialty discipline away from the OR.

These activities constitute an increasingly important component of modern anesthesiology and deserve explicit recognition.

The maturation of anesthesiology as an academic discipline has inspired physicians to devote many hours to the laboratory and to clinical research. Investigations into the science of anesthesiology at the organism, tissue, and molecular levels continue to provide new insights into physiological processes; and to expand our knowledge base. This hopefully permits the development of understanding and wisdom and serves as a basis for tenured faculty appointments. Obviously, a comprehensive catalog of research contributions arising from departments of anesthesiology is best found in the *Index Medicus*. The following brief list is intended to illustrate a few areas in which anesthesiology has influenced other specialties. Many others also deserve recognition; their omission reflects the author's concern regarding an impending editorial deadline much more than their noteworthiness.

- Artificial ventilation of the lungs, beginning with simple anesthesia bags, then negative-pressure ventilators (the classical "iron lungs" of the polio era), finally evolving to modern ventilators and respiratory care.

- Insights into the mechanisms of brain injuries which arose from studies of cerebral physiology in the emerging subspecialty of neuroanesthesiology. Efforts to optimize management of patients undergoing craniotomy provided understanding of factors affecting intracranial circulation and its interaction with ventilation and blood pressure.
- Study of the frightening disease malignant hyperthermia now focuses on calcium misbehavior at the subcellular level, its interaction with normal and pathological contractile mechanisms, and the genetic basis of the disease process.
- Understanding of pulmonary physiology has been advanced by studies of inhaled anesthetics, of acute lung injury, and of the lung's adaption to thoracic surgery.

Pain relief for women in labor has attracted controversy and emotion for over a century. Queen Victoria horrified strict theologians ("...in sorrow shalt thou bring forth...") by requesting chloroform while giving birth. The evolution of "twilight sleep" for parturients enhanced the safety and reputation of obstetric analgesia only marginally. Obstetricians and their patients often felt, perhaps rightly so, that the preservation of a clear mind and airway justified the pain of labor. Modern regional anesthetic techniques enable us to provide excellent pain relief without sedation, at an acceptably small risk. Obstetric anesthesiology is now an acknowledged subspecialty in its own right, complete with several texts, many refresher courses, and a society.

Debate persists between advocates of natural childbirth and those who believe that a properly conducted anesthetic enhances the process of parturition. Although some women enjoy (??) quick labors with manageable contraction pains, others have a first stage which lasts a day or more. A well-managed epidural anesthetic provides comfort with potential restoration of the mother's "pre-contractile" personality, preserves full motor strength, and lowers maternal catecholamine levels. The last has the dual benefit of enhancing uterine blood flow and permitting more coordinated, effective contractions. Thus, modern epidural anesthesia can improve the process of vaginal delivery by allowing the mother to concentrate on her pushing and on her baby, rather than on the pain of the process.

Obviously, there are some who disagree. However, anesthesiologists will continue to

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Anesthesiology

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maintain a presence on the labor and delivery suite, participating in normal vaginal deliveries as well as the care of high risk, potentially critically ill parturients, and in routine cesarean sections.

The field of Critical Care Medicine is our best example of a truly multidisciplinary discipline. Contributions from Anesthesiology, Internal Medicine, Pediatrics, and Surgery have forged a specialty which exceeds the sum of its parts and whose board exams intimidate all. Each of the component specialties has made an important contribution to this field; highlighting one invariably slights the others unjustly. Being loathe to commit any additional sins of omission, and even more reluctant to display my ignorance of modern Critical Care, I defer further elaboration to an upcoming issue of the Hippocrat devoted to this topic.

Anesthesia in alien environments has nothing to do with small green creatures. Rather, the term refers to the proliferation of requests for Monitored Anesthesia Care, or heavy sedation, and for general anesthesia outside of the usual OR environment. Most of these requests arise in the setting of painful procedures or complex diagnostic studies which require patient immobility. Gastroenterologists commonly perform upper and lower endoscopy on awake adults. Colonic endoscopy can usually be accomplished with minimal discomfort in the context of light sedation. However, upper GI endoscopy presents more problems, not the least of which is the potential to impinge on the airway. Topical anesthetics alleviate the pain and interrupt the gag reflex which complicates pharyngeal instrumentation. Patient anxiety is assuaged, and cooperation secured, by providing a thorough explanation of the procedure, reassurance, and judicious amounts of sedatives. While this combination usually succeeds for adults, children are often less persuaded by the argument that "It's just pressure; it doesn't really hurt." Similarly, the torpedo tube interior of an MRI scanner can induce claustrophobic reactions in many otherwise cooperative adults; few children can remain immobile long enough to produce a study of high quality. Even the use of chloral hydrate does not always produce adequate sedation, nor does it preclude motion.

Thus, anesthesiologists are often asked to care for children undergoing upper or lower endoscopy, cardiac catheterization, biopsy of

liver or other organs, and MRI or CT scans. Other examples more pertinent to adults include electroconvulsive therapy, cardioversions, and certain radiotherapy procedures which must be performed in the radiology suite.

For many of these situations, providing complete anesthetic care means nothing more than transporting appropriate medicines, equipment, monitors, and an anesthesiologist to the bedside. Often, semi-elective procedures (ECT, endoscopy, cardioversion) can be scheduled in the PACU or another designated "anesthetizing" location. One might consider these areas to be foreign, but hardly alien. In other cases, we are asked to give anesthesia in spaces specifically designed to accommodate a special function such as radiation therapy. Such locations are not intended to be user-friendly to an anesthesiologist, and in some cases they seem to be constructed with specific attention to inclusion of every possible obstacle to giving anesthesia safely.

MRI provides a good example of an area hostile to the conduct of general anesthesia. Problems are created by the mechanical arrangement of the scanner as well as by the intense magnetic and high frequency electromagnetic (RF) fields it generates. A brief discussion of a hypothetical case provides insight into the difficulty posed by the MRI environment. A 2 year old child with a seizure disorder requires a diagnostic scan. We will assume, perhaps optimistically, the absence of major neurologic abnormalities or other confounding problems, and that an inhalation anesthetic with spontaneous ventilation is chosen.

Before starting, we must realize that any ferromagnetic object will be sucked up against the scanner, potentially with dangerous force. For example, batteries (inside the laryngoscope handles) can become electromagnetic missiles. Much equipment can be made from plastic or aluminum alloys; even specially constructed anesthesia machines are available. General anesthesia must be induced at a safe distance from the scanner. Only when the patient is stable should he be positioned on the MRI table. Gas hoses and monitor leads need to be of extra length to accommodate the patient's journey into the scanner.

During the study, monitoring for this child should include direct observation, auscultation of breath and heart sounds, pulse oximetry, EKG, blood pressure, and expired CO₂ analysis. Unless one chooses to creep into the scanner with the patient (a practice that radiologists do

not encourage), only televised observation is possible. The pictures are not of the highest quality; thanks to a combination of dim lighting and RF interference. One's confidence that expiratory motion and skin color can be readily assessed is not high. MRI apparatus makes noise, and a stethoscope with a 50 foot extension proves to be of little value. FM broadcast microphones usually fail the dual requirements of adequate RF shielding and magnetic neutrality. EKG and pulse oximeter leads can be wrapped in aluminum foil. Signals of minimally adequate quality often obtain under these circumstances, and the two-edged sword of RF interference is revealed: the small emissions from the monitor leads can distort the MRI images, creating a battle of priorities in patient care. Blood pressure must be assessed by oscillometric machines; korotkoff sounds become inaudible amid the clatter of the MRI gantry motion. Again, the unusually long tubing dampens the physiologic signal, degrades its quality, and often prevents accurate measurement. A capnograph which samples CO₂ internally by diverting a small "side stream" of airway gas is our only monitor which enjoys immunity from the invisible forces in the MRI environment. However, gas mixing in the long sample tube and small tidal

volumes conspire to produce blurred or absent expiratory CO₂ waveforms.

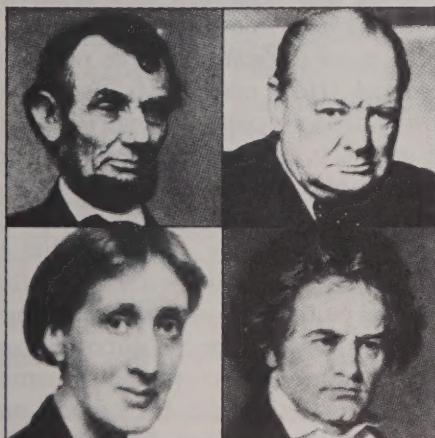
So, the procedure now consists of 4 steps:

- Anesthetizing the child • Establishing a stable pattern of ventilation, the best monitoring possible under the circumstances, and a position for the patient compatible with both safety and useful MRI imaging. • Retreating to a shielded observation area to watch a fuzzy TV image of the patient, EKG and pulse oximeter signals scrambled with equal parts of electromagnetic interference, occasionally a blood pressure reading of questionable accuracy, and perhaps a capnograph waveform. Implicit in this step is the need to extrapolate from this limited information to the child's current condition, the hope that it remains stable, and the knowledge that in any emergency he will need to be removed quickly to an area where he can be treated.
- Extracting the child from the scanner and helping him emerge and recover from anesthesia.

Fortunately, most anesthetics for special procedures are far less stressful. The challenge more commonly is to locate suction and oxygen sources rather than to battle invisible energy fields.

Pain management has also become a recognized

Continued on next page



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Anesthesiology

Continued from previous page

subspecialty of anesthesiology. With expertise in opioid pharmacology and neural blockade, anesthesiologists are especially prepared to interrupt or blunt the perception of pain, and for decades have been leaders in its treatment. Practitioners commonly recognize 3 broad categories of pain: acute pain, usually associated with some demonstrable tissue damage; chronic pain, in which pain persists after an injury has healed, or in the absence of any obvious cause; and pain associated with malignant disease. The therapeutic goals and philosophy of treatment are different for each type of pain syndrome.

Acute pain most commonly occurs in the setting of an injury, be it accidental trauma or a surgical wound. Examples of acute pain syndromes of medical origin include sickle cell crisis, exacerbations of Raynaud's disease, and acute pancreatitis. In most cases, one may expect the pain to resolve concomitantly with the healing process. Treatment is indicated to relieve the patient's suffering during his recovery and to prevent the occurrence of complications which may result from uncontrolled pain. Several obvious examples of such complications come to mind readily; other invite some controversy and are currently being studied. Multiple rib fractures can cause respiratory failure because of splinting even in the absence of a flail chest. Patients who undergo major thoracic or abdominal surgery also benefit from highly effective pain relief. Profound analgesia (accomplished by regional nerve block techniques) improves respiratory mechanics and mechanical ventilation and is required less often. The recent explosion of knowledge in the area of spinal opioid receptors and neuraxial narcotic pharmacology has led to the widespread use of epidural or subarachnoid morphine to relieve postoperative pain. Placement of thoracic epidural catheters permits creation of a regional nerve block which affects the surgical field but spares the legs, thus avoiding both motor weakness which may interfere with ambulation and the postural hypotension which may accompany a major regional anesthetic. In addition, freedom from incisional pain encourages the patients to move, cough, and ambulate.

In theory, such techniques should permit quicker recovery from surgery, decrease perioperative morbidity, and shorten hospitalizations. In practice, this is probably the case, but

it is very difficult to prove. One study, in which patients who required elective ICU admission postoperatively were randomized to receive either epidural or intravenous morphine analgesia, was interrupted after only 53 patients were studied. The incidence of mortality, major morbidity, and prolonged ICU stay was so much higher in the intravenous morphine group that the authors felt obliged to offer epidural analgesia to all such patients. This study has yet to be repeated. Other comparisons of systemic narcotics to modern regional analgesic techniques have provided less dramatic, and occasionally contradictory, results. However, the preponderance of evidence clearly supports the conclusion that profound relief of postoperative pain can be provided with minimal risk, and that such analgesia enhances a patient's recovery from surgery. The growing popularity of postoperative pain management services certainly suggests that patients prefer the newer methods.

A different potential benefit of regional analgesic techniques remains more theoretical. Studies of phantom pain, which may occur following the loss of any body part, have led to the concepts of central nervous system images and neural plasticity. The theory is that the CNS forms a body image which may persist when the body part is altered or amputated. Animal studies show that periventricular microinjections of lidocaine relieve phantom limb symptoms. (How one ascertains that a rat suffers from phantom pain, or that it obtains temporary relief, is beyond me, but who am I to question Dr. Melzack?) A growing body of evidence suggests that severe pain may lead to formation of a "pain image" in the spinal cord as well as in the brain. This is felt to be the cause of central pain syndromes which sometimes complicate injuries or surgery. Since regional anesthetic techniques interrupt the transmission of pain sensations to the CNS, they could prevent the formation of such images. Interestingly, one study showed that continuous epidural analgesia for 3 days prior to leg amputation eliminated the incidence of phantom pain when evaluated 6 months postoperatively.

Pain associated with cancer might be thought of as "recurrent acute pain," since the pain arises largely from tissue injury (most commonly either direct invasion by tumor or nerve compression) and many of the treatment techniques are similar. In most cancer patients, pain can be controlled with oral medications in accordance with the concept of the Analgesic Ladder. Thus, nonsteroidal

antiinflammatories, weak opioids, and stronger oral narcotics are used sequentially, often in conjunction with tricyclic antidepressants. Only when these measures fail is more aggressive intervention indicated. In this patient population, there is no absolute upper limit for systemic narcotic doses. These should be adjusted slowly, with the philosophy "As much as necessary, as little as possible." Concerns about sedation, respiratory depression, and other side effects remain, but issues of dependence and addiction do not pertain to patients with terminal disease. Rarely do we read about drug-crazed senior citizens ripping off convenience stores to supplement their methadone allowances.

Regional analgesia has the same advantages in cancer patients as it does when treating acute pain. Most of the central and peripheral nerve block techniques are performed in the same way, using similar local anesthetic doses. Again, dramatic pain relief and substantial decrements in systemic narcotic requirements are the rule. An additional modality is also available; neurolytic procedures. Nerve blocks accomplished with phenol, absolute alcohol, or cold (-60° C) permanently destroy nerve pathways, and are reserved for situations where the collateral losses are acceptable.

Although modern techniques can alleviate pain of almost any severity, one must remember that patients with advanced malignancy experience multifactorial distress. Although relief of pain may be straightforward, treatment of the patient's suffering is not. Thus, the anesthesiologist caring for patients with terminal illness becomes a member of a team whose captain is most properly the patient's primary care physician. Effective communication among practitioners ensures optimal treatment for these difficult patients.

Evaluation and treatment of chronic pain

often requires input from many specialties. The ubiquitous nature of pain complaints has spawned a long and glorious tradition of soothers and healers, many of whom enjoyed considerable financial and therapeutic success. Since the majority of benign pain syndromes resolve spontaneously, and a placebo response rate of 40% has been documented in a number of careful studies, almost any treatment will "cure" many supplicants. However, some pain conditions require effective intervention before improvement occurs. Most musculoskeletal pain responds favorably to a well-designed course of physical therapy combined with judicious use of nonsteroidal antiinflammatories and analgesics. When pain persists despite appropriate initial treatment, a more aggressive approach to the problem may be necessary.

In many situations, interventions which interrupt or modify pain sensations allow the patient to exercise more effectively and enhance the process of rehabilitation. Increased mobility reinforces the patient's perception of recovery, prevents muscular atrophy from inactivity, and encourages resumption of full activities. This approach succeeds most frequently when accomplished promptly, prior to the development of secondary physical, psychological, or behavioral changes.

Anesthesiologists can achieve temporary or permanent sensory control of chronic pain syndromes using a variety of interventions. The most common procedures in most centers include epidural steroid injections, sympathetic nerve blocks, and regional blocks accomplished by injecting one or more peripheral nerves. The issue of optimal treatment of lumbar or cervical nerve root irritation invites considerable controversy. While few would disagree that a fixed disc herniation with nerve compression and a motor deficit is best approached surgically,

Continued on next page

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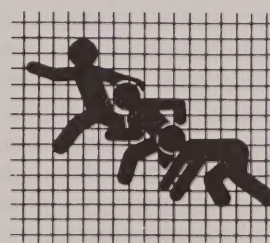
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Anesthesiology

Continued from previous page

other situations are less clear. Some patients have pain in a classic dermatomal pattern associated with normal tomographic studies of the appropriate vertebral levels. Many of these people obtain significant, and sometimes dramatic, relief from epidural steroids, presumably because the steroids bathe inflamed nerve roots, thereby facilitating the healing process. Similarly, the majority of patients with spinal stenosis, a diffuse degenerative disease of the spine, respond to such treatments, noting improvement which may last for years.

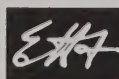
The role of sympathetic and peripheral nerve blocks in the treatment of chronic pain is based on two mutually compatible theories. In some cases, direct injury or irritation of a peripheral nerve produces pain which is usually experienced in the sensory distribution of that nerve. Infiltration of local anesthetic and steroid around the damaged structure interrupts the pain, alleviates the inflammatory process, and permits recovery. Sympathetically mediated pain syndromes can arise following virtually any nerve injury. The pathophysiology remains poorly understood, but current thinking is that an abnormal reflex occurs within the sympathetic nervous system, consisting of abnormal efferent sympathetic activity in conjunction with pain which is typically of burning quality. A diffuse cold sensation, dynamic changes in perfusion to the area, and cutaneous hypersensitivity complete the classic presentation of sympathetically mediated pain. Regional sympathetic blocks interrupt this process, provide pain relief, and potentially cure the disease.

Occasionally, pain syndromes fail to respond to appropriate nerve blocks and the sensory control interventions discussed. Such patients may have been disabled for some time and often require a complete multidisciplinary evaluation. In most comprehensive pain centers, a physician performs a detailed initial examination of all patients referred for management of chronic pain syndromes. Anesthesiologists fill this role in many institutions, although internists, neurologists, or physiatrists may also serve as the triage physician. A diagnostic and therapeutic plan is formulated, which may include consultations by other physicians, psychologists, and physical or behavioral therapists. Treatment must address not only the patient's pain perception, but the emotional sequelae of his pain experience. Issues surrounding secondary gain, in which the patient indirectly benefits from his pain by receiving extra attention or

avoiding responsibility, must be sought out and if necessary included in the therapeutic plan. Although many patients whose pain has persisted for months or years remain well compensated and appropriate, a prolonged pain experience eventually takes its toll on everyone. A crucial feature of a comprehensive evaluation is the assessment of the patient's need for behavioral or psychologic intervention. The triage physician must be familiar with all potential sequelae of chronic pain syndromes and with the resources available to address them.

In this setting, anesthesiologists again function as members of a therapeutic team. They sometimes serve as consultants, performing diagnostic nerve blocks to help delineate the physical component of complex pain syndromes, and treating those patients who benefit from sensory control. Anesthesiologists may also coordinate the process of diagnosis and treatment, directing a referral practice which involves a variety of adjunctive therapies and all the dynamics of a busy outpatient office.

A modern practice of anesthesiology involves far more than the interruption of sensation, disruption of short-term memory, prevention of untoward motion, and preservation of physiologic homeostasis during the stress of surgical procedures. Many anesthesiologists today are consultant physicians with special skills and expertise in diverse aspects of acute patient care. Anesthesiology is now a mature medical specialty which interacts with almost every aspect of medicine and which has made important contributions to our basic science and clinical knowledge. Anesthesiologists may be found on every patient ward, in special procedure rooms, the ICU, the labor and delivery suite, and in outpatient based pain centers. Incidentally, we also put people to sleep. And wake them back up. ■



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A Quest for Anesthesia Safety

Dr. Harvey, M.D. is a staff anesthesiologist at Baystate Medical Center, and the Director of the Pain Management Center there. He discusses the primary but obviously elusive goal of anesthesiology—complete safety.

A patient is mystically pulled through the operating room doors into a bright room, ablaze with lights, high technology equipment and gowned, masked professionals for "routine surgery". Or is it? Anesthesia was not always safe. What are the risks now? How does the anesthesiologist evaluate the biologic variability of patients, balance the response to anesthetic agents, control equipment technology and maintain vigilance to minimize the risk of anesthesia?

The earliest studies looking at the risk of anesthesia were in 1944 during the ether years where a risk of mortality 1:1000 was noted, mostly due to respiratory problems. Becker and Todd's multi-institutional study in 1954 of 599,548 anesthetics determined a primary anesthesia death rate of 1:2,680; most deaths were at the extremes of age and if curare had been given. In the 1960's, reported primary anesthesia death rate was 1:7,692 with over 50% of the deaths occurring in the patient's rooms thus initiating the recognition for routine recovery room care. A decreasing risk has continued since then with a current estimate of anesthetic risk of 1:10,000 to 1:100,000 for a young health patient (ASA I, II) undergoing non-body cavity surgery.

What factors have led to such impressive reduction in anesthesia risk? One factor has been the search for safer anesthetic agents. The initial agents nitrous oxide, chloroform, cyclopropane, and ether were characterized by lighter planes of anesthesia where the surgical stimulation and

sympathetic responses were not blunted leading to cardiac arrhythmias. Airway irritability and secretions were also formidable challenges.

The halogenated potent agents such as halothane, enflurane and isoflurane have been developed with progressively less myocardial depressant effects and more rapid uptake and elimination characteristics, thus speeding induction and recovery from anesthesia. Two newer inhalation agents, Sevoflurane and Desflurane are reported to be even quicker and safer. Newer delivery modes using lower flows (1

liter/min) and closed systems reduce the levels of these ozone depleting fluorocarbons released to the environment and also reduce anesthetic agent and health care costs. An element of mystery still surrounds inhalation anesthesia as we still don't have a *direct* monitor of anesthetic depth. What would you think of a drug that is 4,800 times more potent than morphine? Sufentanyl, one of the newest, most potent synthetic narcotics, binds avidly to the mu receptors (located in the dorsal horn of the spinal column, the brain and throughout the body) that selectively block our responses to pain. It is a commonly used drug along with the other potent synthetic narcotics to block the stress responses to surgery and provide cardiovascular stability. Whereas 5 times the effective dose of inhalational agents may be lethal, greater than 25,000 times the effective narcotic dose can be given without significant side effects as long as ventilation is supported; thus there may be inherent safety in a narcotic based technique. Computer assisted constant infusion technology with blood level feedback loops may refine this even further.

Total intravenous anesthesia using narcotics,

Continued on next page

"In 1944... a risk of mortality was 1:1000... a current estimate of anesthetic risk is 1:10,000 to 1:100,000 for a young healthy patient..."

Quest for Safety

Continued from previous page

propofol (a hypnotic with another mystery of anesthetic action), and newer short acting nondepolarizing muscle relaxants is now possible using constant infusion technology for possibly safer, more rapid anesthetic actions.

There have been new advances in local anesthetics and regional anesthesia. Bupivacaine, an agent for spinal anesthesia, is a more predictable agent with denser spinal block over Tetracaine previously used. Ropivacaine is about to be introduced, which is a longer acting local anesthetic like bupivacaine *without* the cardiac toxicity in larger doses. There is the unifying concept of regional anesthesia and perioperative aggressive pain management, blocking pain impulses before they become established which may decrease the incidence of persistent post surgical pain and the formation of chronic pain states. The combination of regional anesthesia to block the pain impulses from the operative field with lighter planes of general anesthesia for decreased awareness and patient comfort are showing improvements in cardiovascular stability, decreased morbidity and a decreased hospital length of stay in major vascular cases.

Are there any improvements in our ability to define the human factor, the patient variabilities in health and disease? How do we reduce anesthetic risk by cost-effective preoperative evaluation? The major challenge is that the time course of medical evaluation and treatment is now compressed and decentralized with all information and participants coming together the morning of surgery. *An accurate history and physical is still the most effective*

way to screen for disease with laboratory tests confirming diagnoses or optimizing patient status preoperatively. Many studies have shown that batteries of tests produced so many false positive/false negatives and slightly abnormal results that the subsequent harm and costs outweigh any possible benefit. Many national societies along with the American Society of Anesthesiologists have endorsed the concept of reducing preoperative screening tests by selective testing based on a patient's history. An automated, hand held, computerized patient health questionnaire "Health Quiz" has been developed by Dr. Michael Roizen an anesthesiologist at the University of Chicago that integrates the patient's history with defined indications for specific laboratory testing. This reduces over, under, and inappropriate testing for cost effective evaluation. These approaches with decision assisting devices programmed with information based on the literature may open up an entire new field of *medical information systems* as a guide for effective clinical decisions.

There have been advances in anesthetic equipment and the recognition of machine failures contributing to anesthetic risk. Dr. Jeffrey Cooper at Mass. General in the 1980s applied the technique of "critical incident analysis" to detect subthreshold contributions to infrequent events and found errors due to equipment and equipment design that could then be addressed once they had been identified. A far greater number of critical incidences however were due to human error. The Anesthesia Patient Safety Foundation under Dr. Ellison Pierce took the lead in national recognition of these problems and with the Harvard standards for monitoring, pulse oximetry and end tidal CO₂ achieved a remarkable reduction in anesthesia

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morbidity and risk. On the horizon for further improvements in anesthesia technology are the integration of all the separate monitoring boxes, bells, and whistle alarms into a user friendly, integrated workstation. A computer assisted, nationally standardized record with retrieval capabilities similar to the "black box" in aviation would provide a uniform, medicolegal risk reduction strategy for critical incidence analysis and for further education.

There have been remarkable improvements in anesthetic agents, techniques and monitoring technology. Have we reached a plateau where no further risk reduction is possible?

There is a dynamic interface of patient biology, equipment technology and the skill, resources and continued training of the anesthesiologist. How can we reduce the risk of human errors in this dynamic environment?

Similar to aviation there are low frequency accidents still attributable to human errors in vigilance, communications, decision making skills and actions. A program developed by American Airlines with Dr. Thomas Chidester and Dr. Rand McNally, Medical Director of Pilot Training emphasizes the importance of the Crew Resource Management (CRM) in yearly refresher course training in crisis communication skills, crew and resource coordination. Efforts based on these concepts are underway in anesthesiology by Dr. David Gaba, Stanford University, with the development of "anesthesia simulators" a training operating room program complete with surgeons, nurses, and mannequins with monitoring simulations to assess the team response to these infrequent events. Videotaping is used as an educational media to improve the anesthesiologists' communication and quick decision making skills. Examples of simulated events would be for malignant hyperthermia, anesthesia machine malfunction, power outage and various arrhythmias management.

There have been tremendous changes in the health care system with emphasis on increased productivity and efficiency. Prospective reimbursement (Medicare DRGs) has driven anesthesiologists to treat sicker patients, more cases

with less operating and PACU (recovery room) time in more areas of the institution. Like aviation, how do we maintain patient safety, comfort and service while meeting time pressures and scheduling demands? Like the training of the First Officer (co-pilot) in aviation, how do the educational responsibilities of training residents and medical students in Anesthesiology fit into this new environment? Future health services advances will need a national reporting registry to accurately determine the incidence of events for outcomes research. We can then evaluate further decreases in anesthetic risk with new anesthetic agents, equipment technology and human training standards.

These are the advances possible with our technology and anesthesiologists' training in the United States. These programs have led the world's anesthesia community in patient safety efforts. What about the standards of care and risks of anesthesia in third world countries?

It is difficult to imagine: not being able to get narcotics or even aspirin for post operative pain; having to reuse needles and most supplies, if you have any. Transfusions are rare due to the high incidence of HIV in Africa's blood supply where the money is not available to pay to test the blood, let alone the high cost of IV solutions and tubing. There is at least one country in Africa with 26 million people and no M.D. anesthesiologist. There are no gas cylinders; no nitrous oxide; no oxygen; no anesthesia machines. Vaporization of halothane or ether is by draw-over systems and regional blocks are extensively used. Dr. Nicholas Greene, Yale University, has founded and directed the American Society of Anesthesiologist Overseas Teaching Program with the mission of teaching physicians *in their own environment and limited resources* safe anesthetic practice to begin improving worldwide patient safety.

The patient returns from the Operating Room to the Post Anesthesia Care Unit. Awakening with minimal pain, he is relaxed and share a thankful handgrasp with his anesthesiologist for guiding him through his anesthetic risk. His journey through Anesthesia was uneventful. ■

From the MMS Regional Office

To recognize the leadership of women physicians, the American Medical Association (AMA) has designated September as "Women in Medicine" Month.

More and more women are joining the profession of medicine, and this trend is expected to grow. Today, almost seventeen percent or 98,276 of America's 600,344 physicians are women. In 1969, only nine percent or 3,390 women were enrolled in U.S. medical schools. By 1989, the number of women enrolled in medical school had soared to nearly forty percent. By the year 2010, it is estimated that women will represent almost one-third of the physician population.

Both the AMA and the Massachusetts Medical Society (MMS) have taken action to meet the needs of this growing population, and to encourage women physicians and women medical students to become more involved in organized medicine.

The AMA has created a Women in Medicine Advisory Panel, which advises the Board of Trustees on issues of concern to women in medicine. The panel has been so effective that it was recently expanded from six to ten members. Massachusetts is fortunate to have Eugenia Marcus, M.D., as a member of the Women in Medicine Advisory Panel.

In 1981, the MMS established a special committee, the Committee on Women in Organized Medicine. The Committee is chaired by Asha P.

Wallace, M.D., and made up of women physicians, resident physicians and medical students.

The Committee on Women in Organized Medicine, in cooperation with the MMS West Central Regional Office, the Western Massachusetts Women Doctors Group and Baystate Medical Center are planning a fall education program "Sexual Harassment and Gender Discrimination: A Primer for Women Physicians." The program is to be held in Holyoke, MA, on November 1, 1991. Sharyn A. Lenhart, M.D., will examine specific gender discrimination issues, how they impact at different levels of organization and provide a model for overcoming such impediments. Further details and program registration materials are forthcoming.

While the number of women in medicine has more than doubled during the past ten years, the number of women physicians involved in organized medicine has increased just fifteen percent. "Women in Medicine Month" aims to address this disparity through a broad membership recruitment and media campaign. For more information about Women in Medicine Month contact Kristin A. Matthews (x 5959), or Phyllis Kopriva (x 4392), at 1-800//262-3122. ■

*Kerin L. Milesky
Regional Coordinator
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Pharmaceutical Representatives: Not All Bad

Donald J. Higby, M.D. is co-editor of the Hippocrat, and chief of Hematology/Oncology at Baystate Medical Center.

Out in your reception room is a well dressed, usually relatively youthful person who is waiting patiently for a few moments of your time. If you see pharmaceutical representatives, and many physicians don't, you will find a few minutes between patients to hear what he has to say. Because he has been waiting at least twenty minutes beyond his appointment, he will be acutely conscious of the little time he has, and you will probably subconsciously (or even consciously) resent the fact that he is taking your time.

The representative will probably tell you something you already know, leave you with some glossy literature, and possibly drop off another pen or flashlight. The entire encounter may leave you with the thought that maybe you should stop seeing these representatives, but you probably won't change your policy right away, and before you know it, another is at your door.

Leading companies in the pharmaceutical industry have been making a major effort to improve the effectiveness and professional knowledge of their representatives. In one company, (probably most of the large companies are similar) a new representative takes a 12 week intensive course before beginning an apprenticeship in the field. There are periodic updates, some by mail and others through regional meetings. Annual courses are also part of the effort at continuing education.

The representatives see themselves as part of the array of medical professionals, and in addition to serving as the eyes and ears of their company, being responsible for local market research and reminding physicians of their products, they want to be helpful in at least two ways.

First, many companies have indigent patient programs. Pharmaceutical representatives can rapidly work through the paperwork with you so that the process of getting a product for a patient is as painless as possible.

Second, representatives are very knowledgeable in the literature associated with their own product and the disease entities which that product is designed to treat. They also have access to their company's literature searching service, which can be very helpful to a busy physician.

Here is a case in point.

I take care of a lady with advanced cancer, who has had every conceivable kind of chemotherapeutic intervention after surgery and primary chemotherapy failed to cure her. Her disease remains limited to the abdomen, and caused severe ascites which necessitates a painful paracentesis about every two weeks, when I remove about four or five liters of fluid. Her disease is also associated with hypercalcemia, which was becoming refractory to standard treatments. To treat her hypercalcemia, I decided to try a new agent which had just been released onto the market. The product literature said that it should be administered over five days in the hospital, but my patient had a bad case of "Hospitalitis". The pharmaceutical representative was able to find that the drug had been administered in the outpatient setting in another country. With that as precedent, I did the same thing here, and her serum calcium is still normal after eight weeks.

The ascites, however, did not resolve, and I remembered having heard that another agent instilled into the peritoneal cavity had been successful in some patients in controlling malignant ascites. I consulted the representative of the company that made that agent, and she was able to get a literature search about the subject for me in three days. Based on this information I gave the patient the intraperitoneal drug (which the representative was able to get for me under an indigent patient program, since the drug is "not indicated" for the purpose officially.) My patient has not required another paracentesis now for five weeks, and has not reaccumulated any fluid since the last tap.

Both representatives helped me immensely in getting information pertinent to the treatment of my patient, and saved me a great deal of time.

Continued on next page

Pharmaceutical Representatives

Continued from previous page

The information they obtained was from reputable sources (not company advertising) and some of it I added to my own reference library.

There are representatives who waste my time (hardly ever more than two or three minutes, however). There is one that I no longer see; but I think he doesn't work around here anymore anyway—probably his other contacts also complained about him. But representatives that I see over and over again know that I respond favorably to peer-reviewed abstracts and articles related to my specialty, and so they do more of that. And they like to be of service, and feel gratified when they can make a real contribution to patient care.

I am not defending the actions of the drug companies which we all feel are suspect: the premiums; and free "educational" trips; the seemingly exorbitant prices of product. This is all being curtailed anyway. I am neutral as to the value and ethics of "marketing" products which in many cases mean life and death; I guess a case can be made for this in our society especially.

But pharmaceutical representatives can help you care for your patients, and if you don't see them, or if their visits are considered annoyances, you may be missing something. I think their potential value to patient care is greatly underestimated and underutilized. ■



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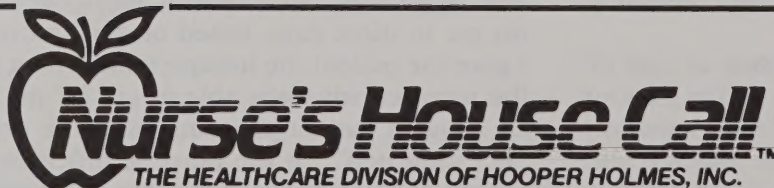
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Insurance Implications of HIV Testing for Physicians

Dr. Lorne Smith contributed the following. He has expressed his views to the American College of Surgeons, the American Medical Association, and the Massachusetts Medical Society, and has been interviewed by the Boston Globe. He urges other physicians to make their views known as well.

There has been mounting pressure for physicians to undergo HIV testing. This is particularly so for those physicians who perform "invasive" procedures.

Whether voluntary or mandatory, such testing will raise a number of questions related to coverage for various types of insurance.

These issues should be raised before such testing becomes widespread rather than after the fact. Our State and National organizations should be aggressive in seeking answers to the questions raised in this essay.

The incidence of HIV infection among practicing physicians is unknown. It is clear, however, that a small number of physicians would test positive.

From a practical point of view, physicians whose professional activity involves patient contact, would have to cease practice on learning of the positive HIV test.

A question would immediately be raised whether or not disability insurance would cover such a physician. Most disability insurance is designed to cover physical impairments that prevent a physician from performing his or her usual professional tasks. If a physician is asymptomatic and physically able to carry out his activities, the insurance carrier could claim that he or she is not disabled. This issue has not been addressed to date.

Along the same lines, the issues of whether or not an HIV positive physician would be eligible for

Medicare disability and/or Medicare health insurance coverage is one that should be answered.

In addition to the above, the issue of workman's compensation is one that will inevitably come up. A physician who claims to have contracted the disease as a result of an occupational exposure could theoretically be eligible for workman's compensation. Again, the fact that the person has no physical disability would create a problem in determining eligibility. This should be clarified before widespread HIV testing of physicians takes place.

Another potential problem is that of health insurance for the physician and his/her family. Most physicians have in the past preferred indemnity type health insurance. This type of insurance is rapidly becoming unavailable and physicians will be searching for new sources of health insurance. A person who is HIV positive will find it almost impossible to obtain health insurance at any price. Some provisions for automatic acceptance if a particular insurance program is cancelled should be sought for physicians who will be in a unique position as far as this is concerned.

The issues I raise here are real and require immediate attention. Our national organizations should ask the insurance companies that cover physicians with disability insurance what their position is on this issue. If some companies will pay and others not, physicians would at least have the opportunity to protect themselves by changing companies.

I have sent a copy of this article to the Massachusetts Medical Society, the Mass Chapter of American College of Surgeons, and the American Medical Association. In future issues I will try to inform you of their response. ■

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STATEMENT OF REVENUE AND SUPPORT, EXPENSES, AND CHANGES IN FUND BALANCE FOR THE YEAR ENDED MARCH 31, 1991

(With Comparative Totals for the year ended March 31, 1990)

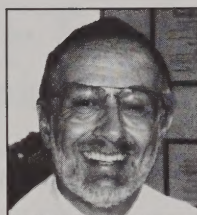
	Year Ended March 31, 1991				Memo Only
	General Operating (Expendable)	Hampden Hippocrat (Designated)	Fixed Asset Funds	Total	Total Year Ended March 31, 1990
REVENUE AND SUPPORT:					
Membership dues and assessments ..	110,375			110,375	105,587
Lectures and other revenue	4,804			4,804	8,402
Interest income	6,503			6,503	5,981
Circulation income		14,793		14,793	18,817
Total Revenue and Support ...	121,682	14,793	0	136,475	138,787
EXPENSES:					
Salaries	44,674			44,674	42,231
Printing	6,011			21,807	18,145
Equipment and maintenance	11,911			11,911	4,951
Public relations	11,229			11,229	13,248
Miscellaneous	8,184			8,184	4,915
Rent	9,460			9,460	
District meetings	7,217			7,217	7,499
Employee benefits and taxes	6,150			6,150	5,418
Springfield Academy of Medicine ...	4,550			4,550	9,100
Scholarships	4,400			4,400	4,600
Telephone	4,254			4,254	3,421
Travel	3,651			3,651	1,283
Postage	3,309			3,309	1,739
Supplies	2,661			2,661	1,647
Committees	1,634			1,634	1,148
Accounting fee	2,000			2,000	2,000
Honorarium	435			435	582
Depreciation			200	200	200
Service charges	72	173		245	85
Consulting		141		141	2,948
Total Expenses	131,802	16,110	200	148,112	125,160
DEFICIENCY OF REVENUE AND SUPPORT OVER EXPENSES ...	(10,120)	(1,317)	(200)	(11,637)	13,627
FUND BALANCE—					
BEGINNING OF YEAR	52,230	2,275	400	54,905	41,278
FUND BALANCE—					
END OF YEAR	42,110	958	200	43,268	54,905

See accountants' compilation report.

Howard Tractenberg:

Anesthesiologist

Howard Tractenberg graduated from New York University School of Medicine in 1960. He trained in Anesthesiology at the Massachusetts General Hospital and then practiced there and at the Beth Israel Hospital until he came to work at the Springfield Hospital in 1970. Now he is chairman of the Department of Anesthesiology at Baystate Medical Center.



Q How do you see the changes that have taken place in the practice of anesthesia in your twenty five years in the field?

A There has always been change. We were talking the other day in our group about how it's pretty scary that people are going to view this time someday as the good old days. I started medical school at about the time that Medicare was being introduced. My father, who was a general practitioner in New York, thought (along with his colleagues) that it was the end of medicine. He thought Medicare was the worst thing that could happen. I got out and those turned out to be great years for me.

Q After you had the makings of an academic career in Boston, why did you come here?

A In 1967, I was vice chairman at the Beth Israel Hospital. I came here specifically not to be chairman. I came here to get back to doing clinical anesthesia. Primarily I was an academic administrator in Boston. There I was getting to spend less and less time doing clinical anesthesia and I really didn't have time to do research. What I was doing wasn't that much fun. I decided that I had gone into anesthesia to take care of patients.

Q How were those years when you first came to Springfield?

A We did have a residency program then. It didn't take that much to have a residency program. Basically if someone showed up on our doorstep who wanted to do a residency we had a resident that year. Some years we had two or three. It was fun and we had some very good people. We had eight anesthesiologists and no nurse anesthetists. We were also covering obstetrics at what was then the Wesson Women's Hospital. For the size of the hospital, the volume of surgery was low. It's only in the past five years that the volume of surgery has expanded.

Q How has the residency changed?

A It takes a lot more time and money now to have a residency. Medicine has become more complex and that is reflected in the structure of the residency. Accountability has become a major requirement for the various boards and residency review committees. If you are going to have accountability, that requires a certain bureaucracy to make sure that what is required is in place.

Q How has the hospital changed?

A When I first came here the Springfield hospital was predominantly a community hospital that had some teaching pretensions with residency training programs going back to the turn of the century. There was no real research activity and that has changed with the mandate from all specialty boards to make research an integral part of training. Before, we had an informal didactic program. Now all of that is very structured. We have always had medical students but now we

have a contingent from Tufts who are spending their entire third year here. Springfield Hospital (and its subsequent reincarnations) has always had a mission to provide some services that the typical community hospital might not routinely provide. Now we've become a tertiary care center. We've recently been approved for pancreatic transplants. Also, as the city has changed we've started to provide some of the services associated with an inner city hospital.

Q Was the arrival of cardiac surgery at the hospital in the late 1970s a major change?

A That was the first major step taken to get into a significant subspecialty orientation. The institution accepted the role that we had always drifted toward. At around the same time medicine was becoming more subspecialty driven. Certain economies of scale were required to in that direction and that was one (certainly not the only one) of the driving factors behind the merger between the Springfield Hospital and the Wesson Memorial Hospital in the mid 1970s to produce the "Hospital of Western New England" which became Baystate. If you were going to provide that kind of care then there was really at that point no other choice. Now we have over 800 licensed beds and 4000 employees and a medical staff in excess of 700.

Q How has the process of delivering the anesthetic to the patients during this time changed in terms of technology?

A I think we focus on the technology, but the new technology is the result of increased sophistication about pathophysiology and pharmacology which has given us a more fundamental understanding of what we do with our patients.

Q Can you give an example?

A In the old days we used ether a lot. Ether had a lot of characteristics that made it an exceedingly safe anesthetic that allows you to have a wide variation in the concentration of drug that you deliver so that the concentration of drug that was delivered to the patient wasn't critical. Subsequently there were anesthetics developed that had significant pharmacological advantages over ether. These new drugs were of increased potency. Whereas you could deliver ether in a range of several percent, we now had drugs that had to be delivered in the range of tenths of a percent. This was a problem and a whole host of new factors had to be

considered in monitoring. For instance, as you evaporate volatile anesthetics they cool; that changes the partial pressure and with these more potent anesthetics the range of temperatures over which you were delivering the anesthetic became much more important to consider.

Q Do you think that the new more sophisticated monitoring available to the anesthesiologist has made his job in the operating room easier?

A The operating room has always been a stressful place but the level of stress in the operating room now is unimaginable compared to what it was not so long ago. In the past, at a certain level of severity of illness of the patient, the surgeon didn't even contemplate operating on the patient. On the rare occasions that a very sick patient was brought to the operating room, the resources that we had at hand were so limited that if the patient didn't do well it was clearly beyond our control. We've come so far now and we have so much more control that you can't take that cavalier feeling any more even with the sickest patients.

Q As a teacher of anesthesiology residents, how do you feel that the life of the residents has changed?

A There's no question the intensity of monitoring and manipulation that the resident applies to the patient has increased. But we used to be up all night, too, doing things like titrating Levophed. I can recall falling asleep at the head of the table because at that point I had been working for over twenty four hours.

Q Well, politically anesthesia hasn't been as reluctant as surgery to reform residency working hours—

A Nobody's been as reluctant as surgery to reform in this area. Surgery is the last specialty that has the concept that the surgeon has to have total control all of the time. Their argument about continuity of care is an important one. I think their solution is an inappropriate one. Nobody can tell me that individuals who are continuously awake are making the same quality of decisions at four o'clock in the morning that they made at seven o'clock the morning before. There's no question that a transition has many hazards when you try to bring in a new team on a very sick patient who is unstable. But to provide continuity of care by keeping the same team there when

Continued on next page

Interview Howard Tractenberg

Continued from previous page

they are exhausted may pose greater hazards. What you need to do is to set up a mechanism to insure that any transition that takes place does so in an optimal way. We do it all the time in anesthesia and in this respect I think that we are a lot smarter than surgeons.

Q So what can you tell us that you've learned since you became chairman (the thing you came to Springfield not to become)?

A I've learned a lot about how to manage change. All change, no matter how obviously advantageous it is, is met with a certain amount of resistance, anxiety, and fear. That's natural. When somebody comes to me with a new proposal I have to say to myself, am I reacting negatively because this is something new and different or because it's a dumb idea?

Q Your father as a general practitioner was much less dependent on the hospital and more autonomous than you could be as an anesthesiologist. Do you think that you are less concerned about possible loss of autonomy than physicians in other specialties might be?

A I went into medicine because of the independence as a profession that it provided me. The fact that I went into anesthesiology tempered that a bit but it still provided much more autonomy than if I was the employee of some large corporation. I suspect that's not an issue for the present generation of students. The service ideal that was always important is still there. But I think those who are looking for independence and autonomy are looking elsewhere. Maybe that's why applications to medical school are down. Medical students' perception now is that they will probably end up being employees of hospitals or HMOs. I think the students of today are not prepared to put in the long hours that were traditionally required in private practice. They want more time for their families and for other interests. Issues that may create anxiety for you and me are not issues for these students because that's the way it is. What created incredible anxiety for my father was not an issue for me. Medicare introduced twenty years of incredible prosperity for physicians instead of being the deathknell of medicine that my father predicted. ■

Brigid K. Glackin, M.D.

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2 Medical Center Drive
Suite 404
Springfield, MA 01107

Born: August 27, 1957
Premed: Boston College 1975-1979
Medical: Tufts Medical School 1979-1983
Internship: Baystate Medical Center 1983-1985
Residency: Baystate Medical Center 1985-1988
Specialty: General Surgery

Colette A. Haag, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: November 6, 1965
Premed: Cornell University 1983-1987
Medical: Thomas Jefferson Medical School
1987-June 1991
Internship: Baystate Medical Center July
1991-Present
Specialty: Obstetrics/Gynecology
Resident

Raymond L. Leonard, M.D.
Baystate Medical Center
759 Chestnut Street
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Born: November 15, 1965
Premed: Fairfield University, Connecticut
1983-1987
Medical: Loyola University-Stritch School of
Medicine 1987-June 1991
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Specialty: Anesthesiology
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Keith R. Ruppel, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: October 7, 1967
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Medical: Northeastern Universities College of
Medicine 1991
Internship: Baystate Medical Center July 1991-Present
Specialty: Pediatrics
Resident

Cornelia C. Taylor, M.D.
Baystate Medical Center
759 Chestnut Street
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Born: November 4, 1962
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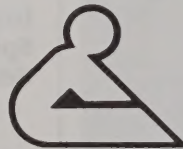
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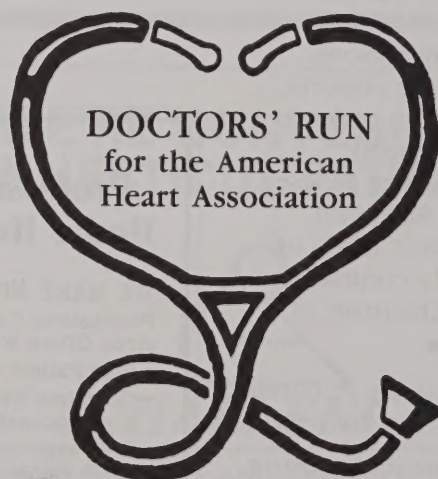
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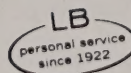
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